Executive Committee
Summary of Meeting Minutes
May 15, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present**	Deb Johnson - **present**
Shelly Chandler –	Liz Matney - **present**
Cindy Baddeloo – **present**	Kevin Kirkpatrick - **present**
Casey Ficek –	Lindsay Paulson - **present**
Lori Allen – **present**	Sean Bagniewski - **present**
Richard Crouch – **present**	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic – **present**	

Introduction
Gerd called the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of April 11, 2018
A vote was taken to approve the April 11, 2018 Executive Committee meeting minutes. The meeting minutes was approved.

Value-Based Purchasing (VBP) Arrangements
Paige Petit stated that UnitedHealthcare (UHC) currently has eight Accountable Care Organization (ACO) contracts.. She stated that UnitedHealthcare currently meets the State's contractual requirements and the organization is currently working with providers to meet the requirement for forty percent of their members to be enrolled in ACOs by the end of 2018. Paige outlined the eight ACOs with whom UHC currently has contracts; Broadlawns Hospital, Iowa Health Plus, Mercy Hospital, UnityPoint Health, University of Iowa Hospitals and Clinics, McFarland Clinic, UniNet Healthcare Network, and Sanford Health (by July 2018). Mike Randol advised that, similar to Fee-for-Service, MCOs are normally paid a capitation payment. He stated that states and the federal government are moving toward a payment mechanism based on value for health outcome wherein instead of paying for the service, the payment is for quality outcomes. Mike stated that with the combination of reduction of cost and improved outcomes for the members, the savings is shared. Paige clarified that the member's Primary Care Provider (PCP) oversees the care of the member to achieve better health outcomes and that the providers membership to an ACO is invisible to a member. J John Hedgecoth stated that Amerigroup has a state contract performance goal of thirty percent of membership in a VBP agreement by July 1, 2018, and forty percent by December 31, 2018. He stated that Amerigroup is making sufficient progress to meet both the July 1, 2018, and December 31, 2018, goals. He stated that Amerigroup uses two key tools to achieve the VBP requirements;Quality Incentive Programs (QIP) and Shared Savings Agreement. QIPs have individual contracts with providers using flexible measurement tools customized by provider type that include programs designed for primary care practices, nursing facilities, and soon for behavioral health providers and facilities. He stated that Amerigroup plans to have six QIPs in place by early 2019. John stated that Shared Savings Agreements are designed for

larger hospital systems and are characterized by individual provider groups who are interested in quality and performance as part of their contract with Amerigroup. John advised that18 of Amerigroup's 20 Medicaid states have some form of VBP program and overall, Amerigroup has 38 percent of their Medicaid services being performed by providers who are part of a VBP contract. Paige stated that UnitedHealthcare is also looking into other hybrid programs such as partnering with smaller providers because if a provider is not part of a large health system, then achieving a larger member enrollment threshold may not be achievable. John stated that in January 2019,Amerigroup is planning to launch QIP programs that are intended to capture in the range of 250-999 members called "*PQIP Essentials*". Mike Randol added that the potential for smaller groups is still being evaluated for viability.

Review of Iowa Code Chapter 249A.4B and Associated Administrative Rules

Gerd reviewed the documents in the materials packet regarding the role of the MAAC and advised of aspects of the medical assistance program that may be considered for future recommendations. Gerd stated that the administrative rules do not prevent the Committee from making recommendations regarding the budget and that this may be a topic for consideration given the meeting of the Council on Human Services regarding legislative directives in August of 2018.

Medicaid Director's Update

Legislative Update

Mike stated that the legislative session has concluded and that there were a number of MCO oversight items present in the appropriations bill that the Department is currently evaluating. The Department will continue to update councils such as the MAAC as additional information becomes available. Some of the reports required for submission to the legislature involve Integrated Health Homes and Health Homes, Medicaid to Medicaid fee schedule alignment, and cost reports for Targeted Case Managers (TCMs). The Department will also be carrying out a Long Term Services and Supports (LTSS) small claims audit, altering Psychiatric Medical Institutions for Children (PMIC) reimbursement from a cost-basis to fee schedule, and continue to have a dedicated provider relations group for provider assistance.

MCO Contracts

Mike informed the Committee that an announcement of award would occur in the near future.

President's Executive Order

Mike advised that the Department is currently evaluating the potential impact of the president's executive order on the state of Iowa and additional information is not available at this time. In regards to capitation rates, Mike stated that they are risk adjusted, all base rates are the same, and the Department will work with the actuary to ensure that rates are actuarially sound for the services that the Department is requesting the MCOs provide. Amerigroup's risk corridor amendment was discussed and Mike advised that the process will take approximately nine months following the conclusion of the fiscal year; six months for accurate claims analysis, approximately 60 days for reconciliation, and a 30 day period in which payment can be made. The final payment determination is made by the Department.

Claims Adjustment Reason Code (CARC) 45 and Remittance Advise Remark Codes (RARC)

Jill Cook of Amerigroup stated that when the code is submitted to them for processing, it must be "clean," without defects, include all necessary information required for processing, and be submitted within the timely filing period. She stated that these are standard insurance billing requirements and added that once clean claims are submitted, providers may check the status of their claim by accessing the Amerigroup provider portal, calling provider services, or working with their clearinghouse. She stated that once a claim has been adjudicated, it will either be paid or denied and if denied, it will be assigned an explanation or reason code. Jill advised that the reason codes utilized are industry standard and the same codes across all payers. She stated that even if Amerigroup uses different internal numbers for codes such as CARC and RARC, they will always correlate to the appropriate industry standard CARC and RARC code number which is reflected in all remittance advices. Jill explained that CARC and RARC do not always mean that the claim has been denied and the internal explanation code explains what action is needed for adjudication. She explained that CARC 45 may explain that the billing has been made for something that the provider is not contracted for or the claim was paid at the existing fee schedule and not at the amount that was billed in the claim. Jill suggested that in anomalous cases of claims payment that it is best to go through the normal claims dispute process.

Open Discussion

David referenced an email he had sent to Director Foxhoven regarding medical necessity

Executive Committee Agenda Item:

- David' to discuss email to Director Jerry Foxhoven regarding medical necessity.

Adjourn

4:11 P.M.